USAF WARFIGHTER CORNEAL REFRACTIVE SURGERY APPLICATION

Application IAW USAF-CRS Warfighter Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) USAF-CRS website or Public Access Public Access

Application Date:

APPLICANT INFORMATION

Last Name	First Name	Middle Initial
SSN (last 4)	DOB	Age
Grade/ Rank	Primary AFSC	Sex ☐ Male ☐ Female
Duty Status ☐ AD ☐ Other	If not AD, please include a copy of current orders	MAJCOM -

Total # months of remaining AD retainability (eligible for elective surgery benefits)

NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.

Unit/Squadron & Office Symbol	Phone (DSN)

Street

Base / State Zip + 4

Duty E-mail

Planned RS treatment Location -

Preferred RS Treatment	☐ Advanced Surface Ablation (ASA) (PRK, Epi-LASIK, LASEK, WFG-PRK)	☐ Intra-Stromal Ablation (ISA) (LASIK, FS-LASIK, WFG-LASIK)	☐ Any Approved USAF RS Procedure

Applicant's Signature

This application form is for use by **USAF Warfighter personnel** seeking CRS Treatment at a DOD (military) facility.

Aviation / Aviation Related Special Duty (AASD) personnel or AF members seeking treatment at a civilian RS center, please refer to the USAF-CRS website for specific application requirements and forms.

FOR USAF-CRS WARFIGHTER PROGRAM MANAGER (WPM) ENDORSEMENT ONLY

Disposition Date	Permission to Proceed? ☐ Yes ☐ No

Reviewing Officer's Name/Rank

Reviewing Officer's Signature

MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

Initials	I am responsible for reading and complying with the policy and guidelines of USAF-CRS Program available at: https://kx.afms.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx or (Public Access) http://www.wpafb.af.mil/library/factsheets/factsheet.asp?id=20427.
Initials	I understand I am **NOT** authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF-CRS Warfighter Program Manager. If granted "Permission to Proceed" authorization, the treatment is not guaranteed. Final decision to treat will be made by the treating refractive surgeon.
Initials	I understand my Commander's Authorization **expires 6 months** from the date of their signature. If I am unable to compete treatment within this authorized period, I will obtain a new Commander's Authorization which must be submitted to the Warfighter Program Manager. A valid authorization is mandatory for USAF-CRS treatment.
Initials	I must inform my primary care manager and eye care provider upon surgery treatment, any required follow-up care, and in the event of any complications. If follow-up examinations as required by policy is not accomplished, I may be restricted from duty until in compliance.
Initials	I understand the final decision whether to perform CRS and/or recommended technique will be determined by my treating surgeon. At any time, I may be disqualified for corneal refractive surgery or I may elect not to undergo treatment.
Initials	If I am disqualified as a CRS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)
Initials	I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after CRS.
Initials	I understand CRS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
Initials	I understand my vision will require time to fully recover following CRS Surgery and there is a risk of not meeting relevant vision standards after CRS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.

Submission of application package: If choosing an AF CRS Center, contact and submit completed package to desired RS Center.If choosing a non-AF RS center, submit completed package for review to: the WPM - Joint Service Refractive Surgery Center, Lackland AFB. mail to: WHMC-CRS@us.af.mil

AF RS CENTER	DSN - Voice	COM - Prefix	FAX	Email Address
Lackland AFB	554-2237	210-292-xxxx	xxx-2313	WHMC-CRS@us.af.mil
Air Force Academy	333-5958	719-333-xxxx	xxx-9774	10MDG.SGOSE@us.af.mil
Andrews AFB	857-2946	240-857-xxxx	xxx-8226	779MDG/wfec/andrewsafb@us.af.mil
Keesler AFB	591-0567	228-376-xxxx	xxx-0155	81MDG/refractivesurgery@us.af.mil
Travis AFB	799-3146	707-423-xxxx	xxx-3529	DGMC.laser.center@us.af.mil
Wright-Patterson AFB	986-0970 / 1447	937-656-xxxx	xxx-0973	88mdg.sgcxa@us.af.mil
JB Elmendorf-Richardson	317-580-1150	907-580-xxxx	xxx-1152	673refractive.surgeryclinic@us.af.mil

WARFIGHTER CRS APPLICATION: OCULAR/REFRACTIVE STATUS (TO BE COMPLETED BY THE APPLICANT'S EYE CARE PROVIDER)

Examination data submitted for Permission-to-Proceed consideration must have been accomplished within 6 months of application date.

Evaluation Date	Last Name	First Name	Middle Initial	SSN (last 4)

Date contacts last worn:

Contact Lens Wear History

Type Worn: ☐ N/A ☐ SCL ☐ RGP — How many days since last worn?

Prior to any evaluation/CRS treatment - contact lens use must be discontinued.

SCL for minimum 14 days.
HCL / RGP for minimum 90 days

Pachymetry (if available locally)

OD		microns
OS		microns

Prior Manifest Refraction Date:

Must be >12 months prior to current exam

OD		-		X		
OS		-		X		

MANIFEST REFRACTION TO *BEST* VISUAL ACUITY

OD		-		X		20/
OS		-		X		20/

CORNEAL TOPOGRAPHY (Explain Abnormal in comments)

OD	OS
☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal

CONTRAINDICATIONS / WARNINGS

Age < 21	☐ Yes	☐ No
> 0.50 D change in sph or cyl in past 12 mos.	☐ Yes	☐ No
Diabetes Mellitus	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Pregnant/Nursing during last 6 months	☐ Yes	☐ No
Electronic Pacemaker/similar cardiac device	☐ Yes	☐ No

Autoimmune disease/immunodeficiency

Dermatitis Herpetiformis	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Vitiligo	☐ Yes	☐ No
Rhuematoid Arthritis	☐ Yes	☐ No

Current/recent use of:

Accutane (Isotretinoin)	☐ Yes	☐ No
Imitrex (Sumatriptan)	☐ Yes	☐ No
Amiodarone	☐ Yes	☐ No
Steroids	☐ Yes	☐ No
INH	☐ Yes	☐ No

> 0.50 D change in sph or cyl in past 12 mos.	☐ Yes	☐ No
IOP > 21 / glaucoma (or suspect)	☐ Yes	☐ No
Keratoconus or corneal irregularity	☐ Yes	☐ No
History of HSV / HZV keratitis	☐ Yes	☐ No
Active Ophthalmic disease	☐ Yes	☐ No
Corneal scars/ Neovascularization	☐ Yes	☐ No
Corneal NV > 2mm from limbus	☐ Yes	☐ No
Visually significant cataract	☐ Yes	☐ No
Hx of prior refractive surgery	☐ Yes	☐ No
Other pertinent ocular history	☐ Yes	☐ No

I have read and will comply IAW AFI 48-123, para 6.20.5 dated 05 November 2013	☐ **Yes**	☐ **No**
I am a USAF Certified RS eyecare provider	☐ Yes	☐ No
Will a USAF Certified RS eyecare provider be available for post operative care?	☐ Yes	☐ No
In your professional opinion, does the applicant meet USAF RS criteria?	☐ Yes	☐ No

COMMENTS:

EYECARE PROVIDER CONTACT INFORMATION

Eye Care Provider's Name/Rank	Unit/Squadron & Office Symbol	Phone (DSN)
Street	Base / State Zip + 4	
Duty E-mail	Eye Care Provider's Signature	